TO: House Committee on Ways and Means
FROM: Paul Harrington, EVP, Vermont Medical Society
RE: Medicaid Reimbursement Rates in Vermont compared to other states – Access to care
DATE: February 4, 2015

Research

"Appointment Availability after Increases in Medicaid Payments for Primary Care,' January 21, 2015, New England Journal of Medicine

Results

The availability of primary care appointments in the Medicaid group increased by 7.7 percentage points, from 58.7% to 66.4%, between the two time periods. The states with the largest increases in availability tended to be those with the largest increases in reimbursements, with an estimated increase of 1.25 percentage points in availability per 10% increase in Medicaid reimbursements (P = 0.03). No such association was observed in the private-insurance group. During the same periods, waiting times to a scheduled new-patient appointment remained stable over time in the two study groups.

Conclusions

Our study provides early evidence that increased Medicaid reimbursement to primary care providers, as mandated in the ACA, was associated with improved appointment availability for Medicaid enrollees among participating providers without generating longer waiting times. (Funded by the Robert Wood Johnson Foundation.)

Physician Practice Setting Influences Access by Medicaid Beneficiaries

1. Physicians employed by hospitals
   Usually unaware of source of reimbursement and no direct impact on income
   Greater potential for cost-shift to private insurance
   Medicaid reimbursement has less impact on access

2. Physicians employed by FQHCs or RHCs
   Usually unaware of source of reimbursement and no direct impact on income
   Since Medicaid reimbursement for FQHCs is typically higher than private insurance, no potential for cost-shift to private insurance
   Medicaid reimbursement has no impact on access

3. Physicians in independent practice
   Usually aware of source of reimbursement and low reimbursement has a direct impact on practice revenue
   Little potential for cost-shift to private insurance due to lack of negotiating power
   Medicaid reimbursement has the greatest adverse impact on access

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Statements by Vermont Physicians on the Impact of the 20 percent cut in Medicaid Reimbursement on Access in 2015

Judy Orton, M.D., Green Mountain Pediatrics, PC, Bennington, VT

My solo independent pediatric practice is 54% Medicaid (average over the past year – month to month may be higher proportion). The past 6 months, we have stopped accepting larger families transferring into the practice with Medicaid (3 or more children) which we've never done. With the 20% revenue drop since Jan 2015, I am holding off (and thus will be late) in paying my bills for overhead, I have cut the hours of the medical assistant by 20% and will not be replacing my billing person (who spends 50% of her time as receptionist) when she retires this summer. I have not hired the needed receptionist but instead rotate nursing staff/ medical assistant (and myself if I am the free person) and the biller in that position. I will continue to do what I can but if I cannot afford to replace staff, I'll have to start limiting new patients to commercial plans and/or when a patient with medicaid transfers it will open a space for another medicaid patient. It is certainly not the open access and active growth for the practice that had always been our policy. In the past I have offset the lower reimbursement of Medicaid by doing many of the behind the scenes jobs myself (or my unpaid husband) - office cleaning, clerical duties, lawn maintenance, office maintenance. There is no place left to "cost shift" expenses and there never has been a place to "cost" shift to commercial insurers as there is no bargaining on fee reimbursement – you accept fees or you don't accept that insurance.

I hope I never have to make a choice as to offer less services because of reimbursement. Unfortunately, I have already reached the point where new services are not affordable and cannot be instituted.

I could also add that Medicaid covers less/bundles more procedures – thus lowering reimbursement. In addition, they do not follow the Fair Claims Process but placing claims in "suspend" for months at a time. You are not permitted to ask about them, you do not get interest payment for being a month past due for payment, and most of the time there is no obvious reason. Occurs most frequently with those 18 and over....but I have a difficult time "graduating" my 22+ year old patients on Medicaid as there is no place for them to go. Therefore I am providing medical services (feeling uncomfortable with "adult" diseases) and often not getting paid and/or not being paid timely.

Joe Nasca, M.D., Pediatrician, Georgia, VT

As the impact of the 20% cut is felt, further limits to patient access will be made.

I can no longer accept newborns of mothers with drug addiction, since I lack the social worker supports in my practice to do proper family centered care for these infants.

I cut my nurse practitioners hours by 50%, thereby limiting female patients' choice of examiner for their well visits.

Steve Hale, M.D., Essex Pediatrics, Essex, VT
We have always taken Medicaid patients and never refused anyone but this year is the first time in over 20 years we have discussed closing our practice to new Medicaid patients because the reimbursement is so low.

Paul Rogers, M.D. Johnson Family Practice, Johnson, VT
I am the only practicing physician for a 10 mile radius. We see about 31% Medicaid patients, which is significantly higher than the area average, and higher than the FQHCs. I am in private practice and have never turned away an area resident due to insurance (or lack thereof) - until now.

I cannot afford to accept new Medicaid patients at the current reimbursement. It costs me $120/hour to run my office (which is extremely efficiently run), and if you do the math it cannot work. I am actually considering dropping some of my newer Medicaid enrollees from the practice. I will not get rich accepting rates tied to Medicare, but at least it's a step.

Richard James, M.D., Family and Sports Medicine, St. Albans, VT
In my work as a family and sports medicine doctor I have found evidence from my patients that Medicaid eligibility is lower in Vermont than in Florida. As a result I have had many patient who relocated to VT to get on Medicaid and then subsequently sign up for our very long waiting list for a total knee/hip replacement.

This is relevant because even if eligibility is lower(than FL) but reimbursement rates are similar(to FL) we still are seeing a much larger demand than we can provide because we attract more patients then doctors (who are more likely to locate in Florida anyway because of fewer Medicaid patients and no income tax).

Therefore access is worse in VT because we have a combination of lower Medicaid eligibility (more demand by patients) and low reimbursement (less supply of physicians who would rather get higher income in another state). NMC and North Country hospitals have been looking for an orthopedic surgeon for 1-2+ years despite steady demand for trauma surgery (a lot of Medicaid) and steady or increasing demand for total knees and hips(mostly Medicare). Both of these hospitals are also chronically looking for Primary Care doctors. I now work in Urgent Care and demand is high because access to primary care is poor. Many patient say they call their PCP's office first but complain because that they can never get in to see their doctor in a timely manner. This is one reason demand for Urgent Care is high in Franklin County despite 3 urgent care centers with a population of 40,000 (this normal supports only one urgent care center).

I hope this initiative helps recruit PCPs as we are chronically in need. Even my wife's (Family Doctor) FQHC which has better Medicaid reimbursement than a private practice is chronically understaffed. Her practice is in Stowe and she commonly has patients drive from Eden or Hardwick because they complain that the (2 closer clinics) are "full".

In the Journal of Urgent Care Medicine from January 20015 the last page cites a study from the Bureau of Health Professionals that shows that:" lack of access to primary care in the US is driving the heightened demand for Urgent Care". The source was Healthcare and Life Science (HCLS) Group at Harris Williams and Co.

Valerie Rooney, M.D., Pediatrician, Brattleboro, VT

The more complicated issue is that not only does Medicaid underpay, but they don't pay for crucial services, or grossly underpay for them, putting the onus on whomever owns the practice to subsidize it. Look up the reimbursement codes for things like attending a c-section, or resuscitating a newborn, and compare with what adult providers are paid. The care of critically ill newborns or children is difficult to maintain and to perform, especially with staff in rural hospitals who often have little or no experience at helping with these efforts, and devastating to families if they are not performed well. I once had a Medicaid official say "Why should we pay you for attending c-sections? All you do is stand there." There was no recognition of the cost to the practice of the pediatrician leaving the office, not seeing other patients, or coming in in the middle of the night (often in the worst weather), or the stress involved.

I also continue to be frustrated by the refusal to pay the 25 modifier, which would allow us to be adequately reimbursed for the complex care of many medically fragile children who require extra time at yearly well visits which we do not get paid for, but allot anyway, because it is the right thing to do.

The prior authorization process for needed specialist referrals and drugs is hugely time consuming. This year, with little notice, we discovered that all off our medically complex kids who see out of state providers, usually for good reason, would have to be changed to DHMC or UVM providers, even if there was not coordinated program such as a Down Syndrome clinic where they could see all their providers together. This once again caused huge amounts of work for our staff that was NOT REIMBURSED for, and more importantly, disrupted care for our patients and their families.

Also, in the past, we have had difficulty as a group and as individuals to even get someone to call us back when there are issues around reimbursement of specific procedures.

Nancy (Anne) Haydock, M.D., Pediatrician, Brattleboro, VT

I don't have any specific stories, but I am an independent pediatric practitioner in Brattleboro which is not a wealthy community. I don't have exact numbers, but at last count my percentage of Medicaid (including Dr Dynosaur) was around 52%, the

percentage of charges is higher, has been as high as 58%. I would never not see someone because of their insurance, but it's not even a choice I have in this part of Vermont (meaning that by not seeing Medicaid does not mean I will have more patients with regular insurance - I don't think they exist).

A 20 percent cut in Medicaid would have a huge impact on our practice. At this point we have put planned cost of living raises for our employees and ourselves on hold. Vermont has been very generous in providing health insurance for children in the state, but it also needs to support pediatricians. It is getting difficult to find pediatricians to come to rural Vermont because we can't offer a competitive salary.